Washington State Department of Social & Health Services

INDIVIDUAL WITH CHALLENGING SUPPORT ISSUES

CLIENT'S NAME	
DATE OF BIRTH	

MENTAL HEALTH DIAGNOSIS	PSYCHOLOGICAL/BEHAVIORAL ASSESSMENT	IDENTIFICATION NUMBER	REGION
☐ Yes ☐ No	☐ Yes ☐ No Date:		

SECTION I **CHECK ONE OR ALL THAT APPLY (DOCUMENTATION MUST BE PRESENT IN FILE)**

	HISTORY OF OCCURRENCE FOR THE PAST (CHECK ALL RELEVANT BOXES BELOW) INCLUDING FREQUENCY (I.E., DAILY, WEEKLY, MONTHLY)		
	1-2 YEARS	3-5 YEARS	5 + YEARS
☐ **Assaultive** (significant aggression or physical abuse toward others) Describe:	☐	☐	☐
	Frequency:		
☐ **Destructive** (major property destruction which puts self or others at risk) Describe:	☐	☐	☐
	Frequency:		
☐ **Self-Injurious** (suicidal, etc.; significant self-injury, danger to self) Describe:	☐	☐	☐
	Frequency:		
☐ **History of misdemeanor-type behavior (may or may not have been charged)** (shoplifting, theft, trespassing, buying liquor for minors, forgery, disturbing the peace, etc.) Describe:	☐	☐	☐
	Frequency:		
☐ **Inappropriate sexual behaviors** (that are not for sexual gratification, i.e., exposing, undressing in public) Describe:	☐	☐	☐
	Frequency:		

SECTION II (ONLY COMPLETE IF AGENCY REQUIRES) **ADDENDUM**

INFORMATION VERIFICATION BY:	COOPERATION WITH SUPERVISION	CURRENT DAY PROGRAM
☐ Police report ☐ Court records ☐ Self-revelation ☐ Parent/guardian ☐ Psycho-social assessment ☐ Other (specify):	☐ Yes ☐ No ☐ Unknown ☐ Other (specify):	☐ Employment ☐ School ☐ Community access ☐ None ☐ Other

CURRENT RESIDENCE

☐ CP ITS ☐ ITS ☐ Group Home ☐ IMR ☐ AFH ☐ ARC ☐ A/L ☐ ESH ☐ JRA
☐ DOC ☐ Parent/relative home ☐ Own home ☐ EARC ☐ CFH ☐ WSH ☐ Other (specify):

SPECIFY OTHER CURRENT SERVICES (E.G., THERAPIES, COUNSELING, MPC, AL, SL, ETC.)

GUARDIANSHIP

☐ Yes ☐ No Name: Type: ☐ Full ☐ Limited

LEGAL STATUS

☐ Current charge pending; if checked, specify: _____
☐ Competent to stand trial
☐ Incompetent to stand trial
☐ Not Guilty by Reason of Insanity (NGRI)
☐ Current Less Restrictive Alternative (LRA) (attach copy of court order)
☐ Currently in jail; projected release date: _____
☐ Probation/parole (attach conditions of probation)
☐ Conditional release (attach conditions of release)

This form was completed based on available information.

CASE/RESOURCE MANAGER'S SIGNATURE	DATE	PROVIDER'S SIGNATURE	DATE

INSTRUCTIONS FOR COMPLETING

Individual with Challenging Support Issues, DSHS 10-234

This form must be part of the DSHS client's placement packet provided to residential providers.

Copies will be kept in the:

- client/case management file;
- resident's file in the facility; and
- a confidential facility file in adult family homes and boarding homes (ARC/EARC/Assisted living). The client name will not appear on the form copy kept in the facility file.

Case manager/social worker responsibilities:

- to provide the forms/copies to the residential provider; and
- to keep the client information on the form current.

Residential provider responsibilities:

- to maintain the resident and facility files;
- to ensure the safety of all of their residents; and
- to inform DSHS/RSN/AAA of any change of condition with regard to the person's challenging support issues.

DEFINITIONS:

Mental Health Diagnosis: Indicate only "Yes" or No." Additional information about mental health issues is in the resident's file.

Identification Number: This number is the case identifier of the authorizing agency.

RESIDENCE TYPES:

AFH ..... Adult Family Home
ARC ..... A licensed boarding home contracted with AASA as an Adult Residential Care facility.
Assisted Living ..... A licensed boarding home contracted with AASA as an assisted living facility.
CFH ..... Children's Foster Home
CP ITS ..... DDD Community Protection Intensive Tenant Support program
DOC ..... Department of Corrections
JRA ..... Juvenile Rehabilitation Administration
EARC ..... Enhanced ARC facility
ESH ..... Eastern State Hospital
Group Home ..... DDD contracted group home with either a boarding home or AFH license
IMR ..... DDD Institution for the Mentally Retarded
ITS ..... DDD Intensive Tenant Support program
WSH ..... Western State Hospital

SIGNATURES:

Case/resource manager's signature: Signature of the placing worker from AASA, DDD, RSN, AAA. The date verifies the form was completed prior to placement.

Provider's signature: Provider's signature verifies that this form/information was provided to the provider prior to placement.